

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

9963

FILED MAR 27 1957

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1961

STATE FILE NUMBER

Health, Welfare  
Public  
Service

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

|  |  |   |  |  |   |
|--|--|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Arkansas</b> b. COUNTY |  |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>ST. LOUIS, MISSOURI</b>   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |  | c. CITY OR TOWN <b>Rector</b> <b>8030</b><br>Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR<br>INSTITUTION <b>Barnes Hospital</b>   |  | Length of stay in 1b  |  | 33 STREET ADDRESS <b>Rural</b> (If outside, give location)<br>Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                      |   |
| 3. NAME OF DECEASED (Type or print)<br><b>MURRIEL</b>  |  | First <b>DEAN</b>   |  | Last <b>BRADFORD</b>   |   |
| 4. DATE OF DEATH<br><b>FEB. 23, 1957</b>   |  | Month <b>Month</b> Day <b>Day</b> Year <b>Year</b>  |  |  |   |
| 5. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>White</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><b>never married</b><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 8. DATE OF BIRTH <b>Oct. 18, 1935</b>  |  | 9. AGE (In years last birthday) <b>21</b>   |  | IF UNDER 1 YEAR<br>Months <b>21</b> Days <b>21</b> Hours <b>21</b> Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (City and state or country)<br><b>Arkansas</b>  |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  | 13. FATHER'S NAME<br><b>Claude Bradford</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Lucille Bradham</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |  | 16. SOCIAL SECURITY NO.<br><b>none</b>  |  | 17. INFORMANT Address<br><b>Lucille Bradford Rector, Arkansas</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>LOBAR PNEUMONIA</b><br><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>MYELOCYTIC LEUKEMIA</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 YRS.</b> |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>                   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Hour <b>4:40 A.M.</b> Month, Day, Year  |  | 20d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                   |  | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  |   |
| 20f. CITY, TOWN, OR LOCATION   |  | COUNTY  |  | STATE  |   |
| 21. I attended the deceased from <b>DEC. 31, 1956</b> to <b>FEB. 23, 1957</b> and last saw her alive on <b>FEB. 23, 1957</b><br>Death occurred at <b>4:40 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.  |  |   |  |  |   |
| 22a. SIGNATURE<br><b>SP Bradley</b>  |  | (Degree or title)<br><b>M. D.</b>   |  | 22b. ADDRESS<br><b>BARNES HOSPITAL</b>   |   |
| 22c. DATE SIGNED<br><b>2/23/57</b>   |  | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   |  | 23b. DATE<br><b>2-23-57</b>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City, town, or county)<br><b>Rector, Ark.</b>  |  | (State)  |   |
| 24. FUNERAL DIRECTOR<br><b>Albert H. Hoppe, 4700 Washington Blvd.</b>  |  | ADDRESS   |  | 25. DATE RECD. BY LOCAL REG.<br><b>FEB 26 '57</b>  |   |
| 26. REGISTRAR'S SIGNATURE<br><b>Carl Smith MD</b><br><b>mjb</b>  |  |   |  |  |   |

(Licensed Embalmer's Statement on Reverse Side)

ARKANSAS

Director

X

Board

General Hospital

SI

Oct. 11, 1932

White

Male

U.S.

Arkansas

Elmer Bradford

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ~~or by~~....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Elmer Bradford*.....

Licensed Embalmer No. 407

P. O. Address *St. Louis*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

Revised S-33-31

Albert J. Hoke, 1100 Washington Blvd.